

## Application for Sliding Fee Discount Program

### APPLICANT INFORMATION

Applicant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License or State ID # \_\_\_\_\_ State \_\_\_\_\_ Sex: Male Female

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_\_) \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

*If married, provide spouse information:*

Spouse's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License or State ID # \_\_\_\_\_ State \_\_\_\_\_ Sex: Male Female

*Responsible party information (if different from applicant or spouse):*

Party's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License or State ID # \_\_\_\_\_ State \_\_\_\_\_ Sex: Male Female

**Household Size:** \_\_\_\_\_ **Include all members in your household:**

Full Name	***	Gender	Birth Date	Social Security #	Relationship to Applicant	Marital Status
		M F				
		M F				
		M F				
		M F				
		M F				
		M F				

(\*check here if the household member is applying for reduced fee services)

Initial here: \_\_\_\_\_





I understand that my participation in the reduced fee program will not be granted until I have completed the verification of eligibility process. Participation in the reduced fee program will be reviewed every 3-12 months depending upon the documentation submitted. Three (3) months for patients with no income and twelve (12) months for patients with income. It is my responsibility to schedule an appointment with TenderCare Clinic at least three (3) weeks prior to the expiration date on the TenderCare Benefits Card to renew my application. My next renewal date is: \_\_\_\_\_ Initial here: \_\_\_\_\_

I understand that my application and documentation must be current in order to receive discounts on services. I must notify TenderCare Clinic within 10 days of a change in address, income, or family size. *Returned mail because of a change of address will stop by benefits until I have completed the application process again.* (If you are homeless, please notify our staff and do not sign this section.) Initial here: \_\_\_\_\_

I understand that discounts on services will only be applied to charges incurred during the approved enrollment dates. I am responsible for the full charge for the visit if I do not complete the application process, are deemed ineligible, or do not provide complete and accurate information. The TenderCare Benefits Card must be presented at every visit in order to receive your predetermined discounts. Initial here: \_\_\_\_\_

I understand that my level of discounts is: \_\_\_\_\_ and not all services are eligible to receive discounts. We expect patients to fully participate in the cost of their care- we do not provide free care. **Payments are required for all patients at each visit.** Initial here: \_\_\_\_\_

I understand that TenderCare Clinic will only grant credit on my account up to \$200.00. I must also have a payment plan in place and be actively working to fulfill my obligation of my patient portion of my charges. Not all services are available for discounts or financing. I understand that I must pay my co-pay at every visit. Initial here: \_\_\_\_\_

I understand that my participation in the reduced fee program can be cancelled if: I move to another county, I have an increase in income level or a change in family size, I am non-complaint with my medical/dental plan of care, I am abusive or show inappropriate behavior with staff, I do not keep scheduled appointments (three (3) no-shows without notice of cancellation or failure to reschedule within 48 hours), I falsify my records/information, I am unwilling to pay patient responsibility portion of charges, and/or I do not maintain my records with TenderCare. I understand that my failure to participate in the provider's recommended plan of care includes compliance with keeping my appointments, participation in the cost of care, pain management contracts, referrals to specialists/diagnostics, medication regime, and other relevant items as ordered by the attending provider. Initial here: \_\_\_\_\_

I affirm that the information I have provided to TenderCare Clinic is true and accurate to the best of my knowledge. I understand that the information I have provided to determine my eligibility for this program that is provided by Federal Funds and is subject to review by Federal and State Audits. I understand that if I have provided false information, my participation in the program will be terminated. Initial here: \_\_\_\_\_

I authorize the release of information to TenderCare Clinic of all data, records, information by insurance companies, providers of medical care, employers, financial institutions, federal, state, or local government agencies, and any other persons, agencies, or organizations necessary for TenderCare Clinic's pursuit of third party reimbursement or verification of statements provided by me or any other person whose income and resources will be considered in this application. I understand that this signed application services as written authorization for any of the above person, agencies, or organizations to release the information required. Initial here: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TenderCare Clinic Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Unemployed/No Income Supplement

1. Are you looking for work? Describe your efforts.
2. Does someone provide you with housing, food, clothing, or cash? If so, please list their names and amount:

Housing:

Food:

Clothing:

Cash:

3. If you have no income and are not receiving help from friends or relatives, please explain:

How do you pay rent?

How do you buy food?

What do you do for cash?

4. Is there a nonprofit or church organization assisting you with your living expenses? If yes, please list name, contact person, and type of assistance.

5. If you report no income, have you applied for public assistance? Yes                      No  
If yes, what type and what is the status?

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TenderCare Clinic Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Documentation needed for Income Verification:**

- \_\_\_\_\_ Last 3 check stubs (for anyone *working* in the household)
- \_\_\_\_\_ Department of Labor Wage and Earning print out (for any *non-working adult* in the household)
- \_\_\_\_\_ Proof of Unemployment
- \_\_\_\_\_ SSI/Disability Award Letter
- \_\_\_\_\_ Proof of Child Support
- \_\_\_\_\_ Proof of Food Stamps
  
- \_\_\_\_\_ Picture ID
  
- \_\_\_\_\_ Proof of Residency (i.e.: utility bill, rental/lease agreement, etc.)

This documentation is due at your next appointment.

**Questions?**

TenderCare Clinic  
803 S. Main Street  
Greensboro, GA 30642  
(706) 454-5153